The Wyoming Public Mental Health System of Care Plan

May 2001 Update

Mental Health Planning in the State of Wyoming is a continuous process. Therefore no planning document, including this one, is ever finished. The unveiling of this plan on November 1, 2000 to a statewide, National, and diverse stakeholder group simply provides opportunity to pursue the following goals:

- **TO CELEBRATE SYSTEM ACCOMPLISHMENTS**
- **TO RECEIVE COMMENTS ABOUT THE PLAN**
- **TO IDENTIFY PRIORITY ITEMS FOR FUTURE ACTION STEPS**

THE WYOMING PUBLIC MENTAL HEALTH SYSTEM OF CARE PLAN

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AND

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WYOMING PUBLIC MENTAL HEALTH SYSTEM OF CARE PLAN

October 2000

A. The Purpose of the Plan.

The purpose of this plan update is to provide a vision for the Wyoming Mental Health System of Care which accommodates, but looks beyond, a lawsuit, the Olmstead Act, or other external influences on the system.

The improved lives of persons served by a system with more comprehensive and accessible, appropriate and effective services than it had five years ago, compels us to plan for a future that is guided by consumers, by our desire for excellence and by a recognition of the economic good sense of treating and managing the most frequently identified mental disabilities in Wyoming and the world. We also wish to recognize that mental disorders contribute to mortality, with suicide being one of the leading preventable causes of death in Wyoming and the United States.

Wyoming State funding for community based mental health services has increased by 125% since 1997 and the numbers of targeted persons served in local communities has increased by an average of 66% during the same time span. Community Mental Health Centers have adopted state of the art rehabilitation and treatment practices and are becoming more integrated with their local communities. The Wyoming State Hospital has transformed itself from a custodial institution into a community oriented inpatient and residential "center of excellence".

Stakeholders in the Wyoming Public Mental Health System of Care have achieved these changes and enhancements, that relate primarily to resolving a lawsuit filed in 1994, guided by a court approved informal "Partnership" process. And overall, the results are quite positive for accessible, appropriate and effective services. But in a sustained and focused response to a lawsuit, there is danger the vision will become limited. It just seems common sense to continuously pursue system design and capacity that achieves cost effective disease management that is healthier for individuals and communities.

Therefore, this is a "living" document. It has been revised twice since it was first penned in May of 1998, the first update occurring January of 1999 and this one which came on line in November of 2000. This action step update was published in May of 2001. The frequency is appropriate, given the number of major initiatives and service enhancements that have been funded by the Wyoming State Legislatures of FY 1997 through FY 2001 and hopefully again in FY 2002.

Money alone cannot build an accessible, appropriate and effective system. The coalesced consensus of a people is also required and a plan can bring alive the spirit and mind of stakeholders. This document places in front of everyone the foundations upon which this system of care stands and the specific goals and objectives that lead to mutually desired outcomes.

An accessible, appropriate and effective system of care is also dependent upon a high, multiple stakeholder investment in the ideas, goals and objectives of that system. Consumers, Legislators, the executive branch of government, family members of consumers, private and public service providers, legal and family based advocacy persons are among the many stakeholders who have provided input that has been incorporated into this plan update. A variety of venues, including community town meetings, council meetings, mail and telephone communication with individuals, ad hoc work groups, conferences and workshops were utilized over the last 18 months to generate and build consensus for the direction and objectives reflected in this document.

B. Themes Imbedded in the Plan.

The themes listed below will be found throughout the plan. They are elements considered important, if not essential, for the continued positive evolution of the mental health system of care in Wyoming.

Consumer Empowerment and Leadership
Stigma Reduction
Integrated Consumers and Services
Research Based and Culturally Competent Services
Stakeholder Based Planning and Policy Development
Flexible Funding
Data Informed Decision Making
Mental Health as a Component of a Healthy Community
Prevention

Consumer Empowerment:
Wyoming needs to move more decisively towards a consumer driven system. We have always been consumer focused, but we are learning what it might be like to have consumer voices speak first and more loudly than other stakeholders. Consumers in Wyoming also are just getting a glimpse of what that might look and feel like. We hope to institutionalize their input to all levels of the system of care, though empowerment and leadership processes.

Stigma Reduction:
We know that for consumers and service providers to become partners, who normally link with local citizenry, that persons with mental disease must be viewed more as fellow citizens with strengths and talents to share. This will require a deliberate, perpetual effort by all stakeholders.

Cultural Competency:
An essential piece for dealing with each other as respected equals is cultural competency. Building this competency may also be helpful in reducing stigma for all sub-populations in our communities. Wyoming has always had awareness of its' diversity, for it could not have become a State without the vote of women. Native or First Americans were here first and though historically disenfranchised, are still here. Railroads were built by the sweat and skill of many persons, including those of Asian and Latino heritage. Ranch and mineral businesses were developed by persons of incredibly diverse backgrounds that include European, Latino, Asian, African and other identified distinct cultures. We have much need to move from being simply aware of our differences, to being competent in dealing with each other's unique background.

Promotion of Healthy Communities:

As Wyoming continues to learn about the strengths and richness of our ethnic differences, we hope also to learn about the strengths and richness of those with mental disease. We know this piece, however, has a different historical and social context that at the least, requires a distinct effort and methodology to impact. Nevertheless, there may be value in tangentially linking those efforts, since perceptions of "differentness" lie at the heart of both, ethnic and disease oriented prejudices.

The Public Health model of a population based, integrated service system for disease management within healthy communities will pervade the thinking, foundations and principles found in this plan. Research has not only proven the effectiveness of the Public Health model, Wyoming ultimately has no choice in the matter. Integrated services not only makes sense, we simply have too few people and resources to afford to build viable systems of care that are independent and separate. While the pioneer spirit is popularly characterized in movies and novels as stubbornly independent, in truth, frontier survival has always demanded that neighbors and neighborhoods ultimately band together. The Wyoming Mental Health System of Care is faced with that same inevitability today; we either band together with all our stakeholders, locally and at State levels, or we gradually fade in relevance, efficiency and effectiveness.

Flexible Funding:

Funding needs to be flexible and more coordinated between State controlled funding sources. Considerable flexibility has been afforded by the Mental Health Division as money flows without many categorical restrictions and accountability reports follow. The Medicaid definitions have been revisited and revised, but a revised document from Medicaid has yet to be placed in use. It remains to be seen whether revisions provide more clear and coordinated service billing potential than the current document does. In the children, adolescent and family service arenas especially, there is significant need for not only coordinated funding of services for multi-issued families, but for more coordinated services period. While cabinet level conversations occur from time to time about these issues, a renewed effort is required to move forward the funding and service coordination areas for children, adolescents and their families.

Integrated Data Supports:

Integrated data supports for informed decision making, is a never ending work in progress. The Mental Health Division, with support from the Wyoming Department of Health and Federal grants is moving towards a state of the art, fully integrated data system. While hurdles remain before information is widely available in useful formats, encouraging developments continue. Data is actually being electronically fed to the Division, secure and public web sites are ready to go for data
processing and accessibility purposes, connecting with a larger, department wide integrated data system is in process and, the Division's current budget request would support the services of a data analyst.

Mental health clinicians have always known that psychotherapy and rehabilitation have been economically viable services. In the early years of the industry, they often were the only people who realized how many individuals retained or gained jobs due to their work together in treatment and how many families remained intact rather than becoming dependent upon welfare supports or how many were diverted from inpatient care that would take them away from their home communities, their families and their jobs. Later, as supported employment and rehabilitation became recognized as viable services for persons with serious mental illness there was more recognition of the financial wisdom for providing these services as well. Now,

finally there is more public recognition that mental health services of any genre has positive impact on all community health domains, including economic.

But we have some distance yet to go before mental health services are routinely included in the larger Public Health efforts made on behalf of communities in Wyoming. Whether training emergency medical personnel, responding to disaster events or hosting a health fair, more often than not, mental health has to invite themselves to the tables of discussion.

Locally Integrated Services:
Integrated services are being explored here and there, in Wyoming often with resounding success. Placing mental health staff in the offices of local Departments of Family Services and on school premises, providing services on site to persons involved with law enforcement, on site or in home supports for employment, all have been quite successfully done in Wyoming. And each community provides unique opportunities and obstacles for integrated service efforts, so the expectation that all integration of mental health services will or should look alike is not and will not be the reality. Are we getting there? Yes, but we have not nearly realized integrations full potential.

Prevention:
Prevention, a proven Public Health concept and practice is developing in the mental health field nationally and in Wyoming. Mental Health Prevention appears to have some areas of specific usefulness while systems of care sort out its' larger potential to impact the lives of persons who may be at risk or already involved in mental or behavioral issues. Suicide prevention activities most readily come to mind where significant returns are gained with proven interventions. Early detection of symptoms and preferably early detection of risk factors is another area where known screening and interventions pay dividends. Wyoming has successfully engaged in major statewide initiatives in both these areas, with positive and broad stakeholder support and participation in both initiatives.

The Institute of Medicine defines mental health prevention in terms of three areas of activity; interventions to ward off the initial onset of mental disorders; treatment that includes interventions to reduce the likelihood of future co-occurring disorders; and maintenance oriented activities which reduce relapse and recurrence, provides guidance for thinking about prevention efforts we may wish to consider in Wyoming.

The general goals of "building resilience," "reducing risk factors" and "development of protective factors" all require specificity of definition, target populations and research proven interventions or activities. Stakeholders in the Wyoming Public Mental Health System of Care are in the early stages of understanding what prevention, as a concept and method of practice, can do for individuals in Wyoming and finding where it fits among existing system priorities.
(Please see Attachment A to view the State Plan on Prevention)

A BRIEF HISTORY OF MENTAL HEALTH SERVICES IN WYOMING

B. An Historical Perspective of Mental Health Services in Wyoming.

As happened in most states, in the beginning of the development of mental health services for Wyoming citizens, the hospital was the only source of services for people with mental illness. In 1890, when Wyoming became the 41st State, its leaders had already shown concern for persons with mental illnesses. The hospital in Evanston, then known as the "Insane Asylum" was built and used in 1887. William Hocker, M. D., was traveling by train to California in 1885 to establish his practice. During a supper stop in Evanston he was asked to examine a young ranch girl who was very ill with pneumonia. As there were no doctors or medical facilities in the area, Dr. Hocker refused to leave the girl and the train continued on without him. Dr. Hocker subsequently established his practice in Evanston, and became an influential member of the territorial legislature.

At the time, Wyoming by law, sent persons with mental illness to eastern asylums, usually in Iowa or Illinois. Dr. Hocker used his considerable legislative influence to get more than $30,000 in State funds appropriated to build a mental hospital in Evanston. When the hospital was completed in 1888 and Dr. Hocker became the first superintendent, two train car loads of patients were returned from Jacksonville, Illinois and were admitted by Dr. Hocker, one male orderly and one female matron. In 1891, Dr. Solier became Superintendent of the hospital and the census at that time was twenty-six. That same year the name was changed to "Wyoming State Hospital for the Insane" and an addition was built to house only women.

Census Progression of Wyoming State Hospital (WSH):
The census grew over 40 years to 325 in 1916, 438 in 1930, 451 in 1950 and admissions averaged more than 200 per year with lots of turnover. In 1964 the average daily census at the Wyoming State Hospital was 686; in 1986 it was 235; in 1992 it was 182; in 1993 it was 140; in 1994 it was 138; in 1995 it was 114 and 134 in 1996. In 1997 it was 75; in 1998 it was 86; in 1999 85 and finally in 2000 it was 63.

In the last three years, there have been coordinated and specific efforts at the hospital and local CMHC's to divert persons with serious mental illness and emotional disturbances to appropriate, less intensive local treatment opportunities. It is hoped to enhance community based capacity for crisis reduction and diversion even more with new State funds in 2002.

Community mental health in Wyoming began in the early 1960's with the passage by Congress of the Community Mental Health Centers Act. The Act conceptualized community mental health centers which would meet outpatient mental health needs of all persons within defined geographical areas. Wyoming continues funding treatment for non targeted persons, but has significantly increased money, programs and services for adults with serious mental illness and for children and adolescents with serious emotional disturbance and their families in the last four years.

Between 1963 and the mid '70s, seven community mental health centers were developed in Wyoming, servicing parts of the State in their service areas. Local initiatives and federal grants were obtained to do this. In 1969 the Wyoming Department of Health was reorganized into a Division of Health and Medical Services, which included a unit for mental health and mental retardation services. During this period, CMHCs received State General Funds by appearing individually before the Joint Appropriations Committee to present budget requests. The "mental health system" was a result of lobbying, with many areas of the State having no services or widely varying services.

The Reorganization Act of 1979 created the Department of Health and Social Services and required the establishment of a Division to administer mental health, substance abuse and developmental disabilities services.

In 1979 the Community Human Services Act created the Division of Community Programs and gave authority to develop statewide CMHC services; to allocate State funds on the basis of population for purchasing “availability of service” in all counties; to determine the type, level and quality of services; and to oversee the quality of CMHC services by promulgating Standards. Uniform services that were to be consistently available statewide were outpatient, liaison, and partial care.

In 1980, Federal Staffing Grants for CMHCs and other Federal Grants were combined into a single Federal Block Grant which States were to use, as each saw fit, to support CMHC services. Wyoming had always used mental health block grant funds to provide seed money to CMHCs to develop new and innovative services for federal priority populations, rather than to enlarge existing services funded by the state or provide operating money on an ongoing basis to CMHC projects or to non CMHC organizations. Recently, the sentiment of the Mental Health Planning Council and others was to provide some ongoing funding to consumer run projects that appeared to have no alternative future funding and for advocacy groups that also appeared to have no alternative future funding sources for “800" number access and information service projects.
These projects began receiving funding in Fiscal Year 1997.

In 1987 the legislature authorized Medicaid funding options. Medicaid has brought new Federal revenue to CMHCs, but initially, no new State matching funds. CMHCs are required to use existing State contracted funds to access Medicaid funds. Beginning in FY 1994, the state Medicaid agency, the Division of Health Care Financing (HCF) proposed to CMHCs that they could reduce their share of state Medicaid match from the full state match rate to 15% match by developing intensive community based services for children and adolescents who would otherwise be in placement outside their communities. By the middle of FY 1996, all CMHCs had qualified for this reduced match rate, thus making more services available to both Medicaid eligible and non-Medicaid eligible clients of all ages. There is no match required of CMHCs in the State of Wyoming for Mental Health Services provided to children and adolescents in therapeutic foster care (TFC).

In April of 1991, the Wyoming Legislature reorganized State Government into twelve cabinet level Departments, one of which is the Department of Health (DOH). A former Division of Community Programs was re-named the Division of Behavioral Health (DBH) and was made one of six divisions within DOH. In FY 1995, the Wyoming State Hospital (WSH) was separated from DBH by the Department Director to whom it reported directly. DBH was renamed Division of Behavioral Health-Community Programs, under a new Administrator. In FY 1997, the Wyoming State Hospital was once again combined with DBH-Community Programs under one administrator. This combined Division was called the Division of Behavioral Health. As described elsewhere, in this document the Substance Abuse Program has now become the Substance Abuse Division and the community based Mental Health Program and the Wyoming State Hospital now constitute a new “Mental Health Division.”

THE

CURRENT

SYSTEM

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C. Description of the Current System of Care.

WSH continues to employ approximately four hundred thirty nine full time staff, 248 of which are clinical. Many of these however are utilized in outpatient clinics, diversion and family education programs on campus. A few are deployed to other locations in the State, such as Lander where a dual diagnosis program was implemented and in the Basin area where a WSH transitional residential program exists. WSH Psychiatrists are physically located in at least two parts of the State and others travel regularly in order to assure that psychiatrist services are available in every County. The financial and staff resources of WSH have and continue to support or be transferred to and originally placed in community based services.

The State Hospital continues to maintain an official bed capacity of 104 for both targeted populations. The legislature has approved a long term plan to demolish or close several buildings on the WSH campus that cannot be brought into safety and service compliance and to replace those with new, state of the art facilities with a reduced number of beds. Funding, building codes and other obstacles made for a slow start on the new 40 bed state hospital building at the south end of the campus. All obstacles seem now to have been addressed and the current projection for this new facility to open is November of 2001.

Service Integration:
It is hoped the legislature of 2001 will fund yet another increase for the system which will assist with integration of services at all levels of the system. One focus of service integration would be to enhance the system's ability to intervene locally when persons need more intensive care and may be unnecessarily considered for inpatient care away from their local communities. Some funds from the Wyoming State Hospital already go to the community based provider system to deliver local services designed to divert persons from an unnecessary use of inpatient beds, either on the state hospital campus or in local communities. Opportunities still are being explored with local community hospitals with psychiatric beds or free standing psychiatric hospitals in the State, to provide State Hospital inpatient services in locations near to person's home area.

In 1995, the MHD implemented a new method of funding for CMHCs. Using increased funding for the two priority populations to implement the change, MHD increased the base funding from $22,500 to $70,000 for each of the 23 counties served by CMHCs. This funding is a guaranteed amount, distributed to CMHCs in even monthly payments, to assure availability of services. The remainder of the state appropriation for community mental health services was distributed among counties on a population basis and was drawn down on a purchase of service basis, until last July, 1998. At that time it was arranged with CMHCs for all funds for the targeted populations to be distributed on a 1/12th monthly basis with the requirement that all targeted persons in the state be served. Provisions for reduced payments exist for CMHCs whose service level may not equal payments currently provided. Funds for the non-targeted populations continue to be allocated by a base of $70,000 per county plus purchase of service funds which must be billed by the hour to be earned. Medicaid continues to be reimbursement by the hour.

Approximately 15 million State dollars is now funneled to the community based System of Care for all targeted individuals, double the approximately 7.5 million available to the community based System of Care in 1996. And funding streams are again being examined to determine if even more flexibility can be provided centers to meet increasing costs for delivering services.
Still funded separately are services to meet the general mental health needs of non targeted populations in Wyoming. Currently that funding level is at $3.2 million. This money may be used for targeted populations at the discretion of individual local CMHCs, but in general, money

for targeted populations may not be used for non targeted populations. The Division does allow a psychiatrist whose time is purchased with targeted money to serve non targeted persons, if all targeted populations are served first and the psychiatrist has free time available. Priority for psychiatric appointment time must be given to targeted persons. This last year, the Division also allowed for SFY 2000 enhancement funds to be used for services to certain subpopulations of persons, such as those with deafness and those who are elderly. Priority must be given to those who are of the targeted populations. Funds for treating persons with co-occurring disorders (mental health and substance abuse disorders) is limited to targeted populations.

Mental Health Division (MHD)

The Division is responsible for administration of the Wyoming State Hospital and for the administration of community mental health programs. Currently, the Mental Health Division has a total of nine (9) staff, two of whom are clerical. The Administrator is responsible for all MHD and WSH staff. A Deputy Administrator assists with lawsuit resolution activities and with oversight of community programs with foci changing according to need. The MHD office in Cheyenne has a Management Information Systems (MIS) Coordinator, a data entry person, a Medicaid Mental Health Program Manager who also functions as the Child and Adolescent Program Manager, a Finance Officer and two Regional Consultants. A third, part time Regional Consultant is funded by the Wyoming State Hospital and serves three counties in the western part of the state, relatively near the hospital.

As delegated to it by the Director of the Department of Health, the Mental Health Division functions as the State Mental Health Authority and has the functions of Federal Grants Administration for its programs, developing and monitoring Standards for community programs, contracting with community programs for services, on site monitoring and technical assistance, budget development and fiscal management of state and federal funds, and management of the statewide MIS. Other Division responsibilities specific to community based mental health include the Level II PASRR process, where persons who are thought to need mental health services and who need nursing home care, are screened, and plans made for their treatment, if appropriate.

Regional Consultation, begun in 1998, has evolved into a combination of statewide duties for carrying forward major initiatives, provision of technical assistance to assigned centers, monitoring of Standards requirements, general field level problem solving and input into Division policy development. Manpower for this has been achieved by redefining and re-prioritizing job responsibilities of existing staff to include this new function. Primary service areas have been identified for each Regional Consultant so that working relationships can be built with CMHC directors and key staff and with key community agency heads and decision makers. This regional service, supported by data, finance and policy persons at the Division continues to assist with the implementation of our many new program, conceptual and administrative changes of recent months. Providers especially value the function.

In 1992, the MHD engaged in a comprehensive planning process for all programs of the Division.

At the former Governor's initiative, a Partnership was created in 1995 to resolve issues relating to a civil lawsuit alleging inadequate and inappropriate mental health services and service capacity at the Wyoming State Hospital and at community mental health centers. Using eight task forces it developed a 5 year plan that had guided development through 1997. During that year additional ad hoc committees of the Partnership for the Resolution of Mental Health Issues in the State of Wyoming met continuously to propose community based services that would

better serve adults and youth with serious mental illness or disturbance. That planning was supplemented however, with a more broadly based and consumer inclusive series of meetings by four committees attached to a state level "21st Century Workgroup". Those committees covered funding, statewide goals and objectives, covered services and system guidelines. The committee of the whole or the "21st Century Workgroup" consolidated the four sets of findings and recommendations into a comprehensive "Wyoming Public Mental Health System of Care Plan", which was accepted by the Partnership and the Legislative Oversight Committee for presentation to the Legislature for funding. 21st Century Workgroups and new ad hoc committees have continued as a planning and input resources to Division of Behavioral Health. Other subcommittees of that group also continue to support development of the public mental health system, such as developing practice guidelines for clinicians. Out of this wide input and consensus building process was born the "Public Mental Health System Plan of Care" document, created in 1998.

Using even more public, consumer and provider input, this document is now being updated and will include plans to carry the system forward for the next four years. A statewide "unveiling" event introduced this document on November 1, 2000.

The Mental Health Planning Council has increased it's membership to include more consumers and has decided to increase it's scope of interest to include the whole Mental Health System of Care. The Council has also agreed to act as an advisory group to the MIS development grant. The Council recently invited nationally sponsored (NAMPAC) training to be done, in light of the numbers of new members appointed during the last 6 months. Orientations by Division staff are invited to occur about once a year. Members appear excited about recent membership expansions and about exploring possible new roles it might play in system development.

Community Mental Health System:

The community mental health system in Wyoming is comprised of sixteen (16) community mental health centers (CMHCs) , thirteen of which also provide state purchased substance abuse services. Two of the CMHCs serve four counties each, and another CMHC serves two counties. The remaining CMHCs each serve one county. In three counties, CMHCs have two full-time offices in different towns. In many of the other counties, CMHCs have part time offices in some smaller communities.

CMHCs are not-for-profit, private organizations run by citizen boards. The Mental Health Division contracts with these boards for State purchased mental health services and for services funded by Federal Grants. As State certified CMHCs, all sixteen CMHCs are eligible to provide covered outpatient mental health services under provider agreements with the state Medicaid agency, the Division of Health Care Financing.

County governments in Wyoming are not directly involved with mental health services, but many Counties and some cities provide modest grants to CMHCs and some Counties have provided a building space for the CMHC. Financial and in-kind contributions from county and city governments, the citizen board structure, and the MHD purchase of state funded services contribute to a tradition of strong local "ownership" of mental health services and strong local control. This local control is enhanced by the politically active Wyoming Mental Health and Substance Abuse Centers Association which includes CMHC executive directors and board members.

Services offered by all CMHCs include clinical assessment, agency-based individual/family therapy; group therapy; hospital liaison services; consultation and educations services; 24-hour

emergency services; examiner functions under the Civil Commitment Statute: and Level II PASRR evaluations. Clients receive case management and psycho social rehabilitation as needed, according to a treatment plan.

All centers also offer on-site medication management. Some centers continue to offer day treatment and all now provide community-based individual/family therapy, individual rehabilitative services, and vocational services, with variation in amounts and models. Six centers host community support projects called Supported Independence Projects (sips) for adults with serious mental illness. SIPS include residential services, intensive case management and psycho social rehabilitation. The $1.4 million in funds for these are now incorporated into regular contracts with involved providers, but still have separate budgets and reporting requirements.

The grass root political system of Wyoming still strongly supports a tradition of providing mental health services to all persons in the community, regardless of level of disability. For FY 00, services to these non-targeted populations are funded at $3.2 million. It is consistently reported that mental health service for the general community is what generates local dollars and support from State and National Legislative Representatives. The recent funding increases, all of which are targeted to SMI and SED by CHS definitions, are clearly the result of a Legislative desire to avoid lawsuit defense expense and maneuvering. Over the last 4 years especially several Legislators have developed a good understanding of, and interest in, the actual results for Wyoming citizens with serious mental diseases. The Division of Behavioral Health still plans to use data from its' integrated MIS which includes performance measures and outcome information, to guide the Division and stakeholders about its successes and needs regarding services for the target populations.. The grass root political system has been surprisingly supportive of adults and youth with serious mental issues. The Division will be carefully exploring Legislative interest in maintaining a balance of financial support to both non targeted and targeted populations. It is simply too soon to know of the effect the Olmstead decision in Wyoming.

Another feature of Wyoming's community mental health system is its close integration with community substance abuse treatment. In twenty of Wyoming's twenty-three counties, the CMHC provides both services, often with the same staff. Therefore, funding for mental health services and funding for substance abuse services are mutually interdependent in enabling either service to be viable in most counties. Considering the recent creation of separate divisions for those programs within the Department of Health, it remains important that both Divisions actively assure coordination of policies, standards and funding streams. That commitment has been expressed by both Division Administrators.

In 1994, the Protection and Advocacy System, Inc. and the Wyoming Alliance for the Mentally ill (WYAMI) filed a suit on behalf of five individuals against various state officials regarding multiple deficiencies at the State Hospital and insufficient community based services for both adults and for children and adolescents.

Pre litigation of negotiations during 1994 failed to produce a settlement. As a result of renewed negotiation in 1995 there was an agreement to try to work out solutions without further litigation. The agreement (called the Stipulation) was accepted by the court on September 22, 1995 and included the Partnership enabled by the Wyoming Executive Branch of government (the former and current Governor) mentioned earlier. The Stipulation formally created the Partnership for the Resolution of Mental Health Issues in Wyoming which includes the Director of the Department of Health, the Executive Director of Protection and Advocacy Systems, Inc, a representative of WYAMI and the Administrator of the Division of Behavioral Health. There is a

paid facilitator from the University of Iowa. Attorneys for the plaintiffs and the state participate, as do an ad hoc member who is a community mental health center director and ex-officio members from the Department of Education and the Department of Family Services. The Deputy Administrator of the Mental Health Division serves as the Administrator for the Partnership.

Briefly, the purpose of the Partnership is to monitor, discuss and recommend system changes that would successfully bring closure to the lawsuit. The principles being pursued by the Partnership are CASSP principles for children and adolescents and community based treatments and supports for adults, all in the least restrictive environments possible. The Mental Health Division has adopted Recovery Principles for the system of care as well. Those principles are being introduced Statewide this September, 2000 by Wilma Townsend of Ohio. Out of that experience and with the input of stakeholders, a consensus built implementation plan will emerge by the end of the calendar year.

THE BASIC FOUNDATIONS

OF THE

WYOMING PUBLIC MENTAL HEALTH

SYSTEM

OF

CARE

I. The Basic Foundations of the Wyoming Public Mental Health System of Care

A. A Multi-Level, Responsive and Flexible System of Care.

In the mid 60's and early 70's the choices for persons needing mental health services were simple but sometimes heart rending, inpatient treatment or outpatient treatment. And it didn't matter how much money you had, the choices remained the same. Those with money got into private hospitals where the surroundings may have been better than that at State Hospitals, but the medications and treatment were not likely to have been significantly better. The same cycles of care occurred for everyone at the mercy of the system, whether private or public. Now, a few more choices are present, but not enough to assure that all levels of care are available near the home communities of all persons, especially for those without insurance or considerable elective resources.

Wyoming has doubled the amount of state funds available to the community based system of care since 1996 and that has enabled a remarkable improvement in local care for persons with serious mental illness or emotional disturbance. Case management now assures that comprehensive plans are in place and that some level of monitoring is available for every identified adult and child with serious illness. Group and supported residential care is available in 6 locations in the State. Supported employment services are available in every County and to every identified person who could benefit. The services of a psychiatrist are now available in every County of the State ,as are, medication monitoring and support services. State of the art rehabilitation treatments are in place in most Counties, with others doing the best they can with resources and populations available.

Forensic evaluations are increasingly available in local communities. As noted earlier in this document inpatient care at WSH has become state of the art in its' basic practices and provides alternate treatments, levels of care and residential supports. The ability to move freely between these services or to use more than one at a time is facilitated by integrated management teams which operate fluidly at multiple levels.

Gaps, some significant, still exist in services and basic resources. For the system to be as flexible and comprehensive as needed to efficiently use these new and enhanced services and to best serve targeted populations, those gaps need to be addressed. There is need to enhance local capacity to respond to crises and cyclic symptom exacerbations. Three to ten days of intensive residential care and introduction or re-introduction of medications in a local or close by community is much more humane and less expensive than a trip to the Wyoming State Hospital for an unnecessary admission there. Supported employment needs to be enhanced to include supported education and career development rather than to "just have a job." The time and dollar costs of involuntary procedures needs to be evaluated, and most likely shortened and reduced. Psychiatric Advanced Directives enabled in Wyoming with recently passed legislation will eventually improve crises reduction and what now becomes involuntary treatment episodes, but it will not improve involuntary experiences for those new to the system or for those who choose not to use psychiatric advanced directives. Respite care for both adults and children and their families need considerably more enhancement or development. Ready access to regionally available inpatient care needs to be more fully explored for all consumers, regardless of funding sources. Forensic evaluations need to be available in more communities. Services to persons involved with law enforcement, judicial and/or corrections systems needs further evaluation and probable enhancement.

Services to Children and Adolescents and the families needs focused and sustained attention at all levels. The diversity of funding streams and service orientations among the multiple child and adolescent service organizations is at once overwhelming and often at cross purposes for families trying to get help for their child or children. Perhaps the most daunting choice families regularly have to make is to relinquish custody of their minor child or relinquish access to vital funding for treatment. When they do, residential services including inpatient care, is often many hours away from their home communities and not infrequently, out of State. Accessing and coordinating services for children with emotional disturbances is often as stressful and energy consuming as is coping with the child.

Transitional services for older adolescents also needs attention so that people don't have to "start over" or perhaps lose valuable momentum in their recovery process. Jumping from high school to jobs or college is challenging enough and those with brain disease could benefit greatly from smooth "hand offs" from one set of support systems to another set.

We need to renew the effort at the State and at local levels to coordinate the activities surrounding treatment and support needs of children, and their families, who are in trouble.

We need to pay attention to the basic operational supports for the system. We have been busy enhancing services and redirecting resources and energy to those with serious problems, and rightly so. While doing those good things, the costs of doing business, in general, has been creeping up and enhanced services has created demands for more operational space, clinical and support staff and more volunteer involvement by directing and advisory boards.

Flexible funding streams, enabled by the legislature and by Division policy for the State Hospital and local Systems of Care have enabled not only increased services, but new facilities and the creation of state of the art treatments at all levels throughout the Wyoming Public Mental Health System of Care. It is essential that the State Hospital and the local Systems of Care be able to tailor their services to local and State wide needs, and swiftly shift resources to create new services as new technologies make possible and which people demand. The flexibility to respond quickly to the rapidly changing public health and mental health environment is essential for Wyoming to become and remain competitive. When you add in the practicality of risk management that this foundation adds, it is simply the prudent way to go. We are fortunate and happy to have as much of this foundation built as we do and it makes good sense to continue doing so.

We need to acknowledge the support of the Executive Branch of Government and the Departmental support of Division administrative creativity and leadership, the WSH administration, the local CMHC Directors and the Legislature in achieving these flexible funding outcomes. New facilities have been built and continue to be built at the State Hospital because of the willingness of the Legislature to let here-to-fore returned revenues remain at the hospital, ON LOAN. And once the loans are paid off, a portion of those revenues generated at the hospital will be placed out into communities for further treatment enhancements there. It has been mentioned earlier in this document that State General Funds constitute only 50% of the total revenues of the community based System of Care. Local CMHC administrators have done an admirable job of doubling those funds for treatment purposes. The multi-party mutual trust that enables these arrangements may be unique in the United States. Given the human foible factors always extant in such arrangements, this trust is something to be valued and celebrated.

B. Collaboration between the system and stakeholders.

The above paragraph addresses some of the funding linkages among the players, but the Division Administrator, in his leadership program development strategies, has created many stakeholder input mechanisms. Short and long term ad hoc work and focus groups are continuous input opportunities created by the Division Administrator. Existing connections, for example those with local community based providers, State Government Cabinet and Department level groups have been enhanced over the last 5 years. The informal Partnership for the legal resolution of mental health issues in Wyoming has been expanded to committees and sub-committees for various purposes. Accumulatively, the result is a large and diverse set of inputs to the whole system at multiple levels.

Do we have need to improve consumer input to the System of Care components? Yes, much. But we have written plans to do that via a grant application for Consumer Leadership Academy model activity throughout the State. With or without a grant award, we will move that model forward, albeit, if not Federally funded, in a modified form and pace. Do we need better education for families of persons with serious mental illness? Yes. But we have in motion now, a Family to Family Education Program funded with Mental Health Block Grant funds. Is there need for more input? Always, and we intend to have it continuously and as technology increases our opportunities via web-sites and e-mail, we shall do so.

C. Cultural Competency. (see attachment)

The Division will follow the standards created at the Federal level and structure a plan over the months ahead which incorporates both the Federal guidelines and standards with the specific needs of our State. The Wyoming plan will include:

- Guiding Principles
- Overall system standards and implementation guidelines
- Clinical standards and implementation guidelines
  Provider competencies

The Division has been promoting cultural competence over the past year through various activities and planning. The Division has provided several workshops and presentations on the basic fundamentals of cultural competency. In the past two months, we have formally created the position of a *Cultural Competency Coordinator.* This individual is responsible for developing and implementing a cultural competency plan. The Division will also continue to provide technical assistance, education, training, and consultation to consumers, families, communities, and service providers regarding culturally competent services. Our overarching goal is to be the role model at the State level on how to proceed with embracing the role of cultural competency. (See Attachment B to view the full plan for Cultural Competency)

D. A data informed system. (see attachment)

Data is an integral part of quality assurance and accountability that not only enables the system to make decisions, it also assists with the mutual trust described above. By informing all stakeholders of the system's experiences and status, confidence is inspired not just because the system can justify itself, but also because everyone knows that decisions are made on basis of fact. Confidence is then also afforded to new directions and changes because those also are based on reliable and open information.

Wyoming, as alluded to earlier, continues to develop a comprehensive, integrated data system. An article. “Using Web-based Technology to Implement and Monitor Outcomes for Children and Adults in State-Supported Behavioral Services” attached to this document describes, among other things, Wyoming’s current directions to assist the Mental Health System of Care become a “data informed system.” (See Attachment C)

E. Principles and best practice guidelines. (see attachment)

They identify the nature of services persons can expect to receive in a System of Care regardless of where they prefer to access that service. CASSP has been adopted by the Mental Health Division for child and adolescent services it purchases from providers. CASSP principles may need to be more uniformly adopted throughout the system. Recovery Principles are being introduced to the system and rehabilitation principles are utilized for Adults with serious illness. Best Practice Guidelines, as developed by Providers, Consumers and the Division are utilized for clinical guidance throughout the system. (See Attachment D)

F. Integrated Services.

Following the successful precedent set by the National Public Health System, the Public Mental Health System of Care in Wyoming desires to more extensively connect with sister agencies in local communities and connect with potential persons to be served in the natural habitats of those persons. It is hoped that these connections take the system beyond the usual “coordination” of services to the provision of mental health services at sites where at least one other and hopefully multiple services are delivered at normative settings in the community. This could range from doing a mental health intake for an elderly person at a physician’s office to spending a day a week at a social service office delivering clinical mental health treatment services. School settings for youth and their families, presenting programs at youth groups in churches, doing group therapy at probation and law enforcement offices or other locations where youth either naturally hang out or receive other services. Extension services for our many farm and ranch families also provide venues for natural settings for outreach, education and in some cases, treatment to this population. Not only do we hope the mental health system of care develops sensitivity and competency at working with new colleagues, but sensitivity and competency at working with identified sub populations.

It is the intention of the Division to undergird identified populations in Wyoming with foundational skills; a responsive and flexible System of Care that includes stakeholders input, cultural competency, data and information loops and our best practice guidelines. Wyoming has pockets of excellence already in place. We hope to have a more even distribution of state of the art services, at least regionally, throughout Wyoming.

G. Focused or Specialized Services.

Three statewide task force groups were launched October 16, 2000 to identify issues, training and resource needs and best practice guidelines to improve services delivered to the three identified populations mentioned above; the elderly, persons with co-occurring disorders and persons who are deaf or who are hearing impaired. Multiple stakeholders are involved with all three groups, including consumers, private and public providers, legal and law enforcement personnel, medical professionals, sister agency heads or designees and other persons whose perspective better prepares the system to deliver effective and appropriate services.

1. **The Older Adult** has been targeted for identified services by each community mental health center in the state, beginning July 1, 2000. For this fiscal contract year local mental health centers were asked to submit a brief plan for reaching out to and serving the elderly in their service area. Routine visits of mental health staff at Senior Citizen Centers, participating in health fairs at senior housing units, home visits by mental health staff, whole family approaches to treatment, and regular consultations with nursing homes are just some of the venues that have been included in outreach and service planning by mental health centers. Connecting with public health nurses for consultation and conjoint home visits, doing initial evaluations at physicians offices, social service offices and other places where seniors regularly seek services are other methods included in the list of explorations that will be done in the next 12 to 24 months by local mental health center. It is well known that mental health services are greatly underutilized by persons age 65 and older and that even when served, they are often inadequately psychologically evaluated, physical exams may be cursory in relation to behavioral or mood issues and treatment not delivered in natural settings by persons who may not be comfortable and competent with the aged culture.

2. **Persons with Co-Occurring Disorders** has also been targeted for identified services by each community mental health center. This task force will survey the System of Care and develop a summary status report regarding services currently in place for this population, identify obstacles, and using established national models develop a set of best practices for the treatment of persons with co-occurring disorders. Again, there are pockets of excellence where persons with co-occurring disorders receive services appropriate for their needs. It is hoped the work of the task force can provide impetus for the development of models throughout the State that more strictly adhere to proven research treatment elements.

3. **Persons who are deaf or hearing impaired** also received identified services, using appropriate assistive persons and making accommodations as are necessary and which are reasonably supplied. A existing task force for this group is being reformed and "rejuvenated". Later in November of this year a statewide tele-conference will be hosted by the Division that promotes the cultural sensitivities and awareness and basic clinical skills necessary to begin appropriate treatment of persons with hearing issues. The task force has identified a series of events that should promote more clinical and cultural competencies within the public mental health system of care as it relates to this population.

H. Basic Plan of Care.

Prevention, Clinical Services, Quality of Life Supports and Specialized Services are made available to all persons receiving treatment and support from the Wyoming Public Mental Health System of care, as appropriate to their individual needs. The array of services available, in outline form are as follows:

1. **Prevention**
   - a. Information Dissemination
   - b. Mental Health Education
   - c. Mental Health Alternatives
   - d. Outreach, screening and early identification
   - e. Community Mobilization
   - f. Community Coping Improvement

2. Outpatient Clinical Services

a. Clinical Assessment
b. Treatment Planning
c. Therapy Services
d. Psychiatric Services
e. Crisis Response
    i. Emergency Telephone Crisis Intervention
    ii. In Vivo Crisis Intervention
    iii. Hospital Intervention
    iv. Gatekeeping

3. Residential Services, including Inpatient Care

a. Local Acute Stabilization
b. Regional/Wyoming State Hospital Intermediate Care
c. Wyoming State Hospital Long Term Care
d. Therapeutic Foster Family Treatment

4. Recovery and Rehabilitation Services

a. Functional Assessments
b. Skill Training
c. Supported Education
d. Supported Employment
e. Supported Housing Services

5. Mental Health Education

a. Client Education
b. Family Education
c. Community Education

6. Case Management Services

a. Linkage
b. Monitoring
c. Referral
d. Advocacy
e. Liaison

7. Quality of Life Services

a. Medications
b. Emergency Subsistence
c. Transportation
d. Health Care
e. Housing Assistance
f. Recreation
g. Empowerment Supports
h. Financial Services, including guardianships

8. Focused or Specialized Services

a. Services for Persons with Co-Occurring Disorders
b. Services for Persons in the Forensic Population
c. Services to Persons who are Elderly

d. Services to Persons with Serious Mental Illness and with Serious Emotional Disturbance and their Families
e. Services to Persons who are Deaf or Hearing Impaired

MANAGING AND FINANCING

THE

SYSTEM

II. Managing and Financing the System.

A. Policy development and Planning are a constantly evolving process in the Wyoming Public Mental Health System of Care. Many groups have input into the Division for both planning and policy development purposes. Those include:

The Mental Health Planning Council.

This group of Governor appointed members has, in the last year, decided to expand the scope of its' interest and monitoring activities beyond the annual application for Mental Health Block Grant funds. The Council will begin looking at information about the whole System of Care. This has always done to some extent, but usually in relation to understanding the annual block grant application. Additionally, the Council now functions as the advisory group to a grant for the enhancement of our data system and wants to hear presentations and reports from providers about the various services they provide. The Council, this last year also changed it's philosophy about the nature and scope of projects funded with block grant funds. Rather than funding up to 25 small start up service projects around the State, it is experimenting with funding statewide initiatives. This year it used most of the funds to purchase statewide outreach activities by local mental health centers, to satisfy a question of whether persons were still falling through the proverbial cracks in spite of increased funds in recent years.

The most enduring and generally endearing quality of the Council has been and remains it's forthright, open and sometimes contentious airing of the issues of the system. Legislators, consumers, providers, sister state agency heads, family members of consumers, protection - advocacy staff, division staff and guests alike put their thoughts, agreements and disagreements on the table. Division staff walk away with a rich understanding, not only of obstacles but of the heartfelt and documented needs of our constituency. Definitely, these discussions impact system wide policy changes or development.

The Partnership for the Resolution of Mental Health Issues in the State of Wyoming (The Partnership)

This Governor enabled, court approved and empowered group began in 1994, input and planning processes that have resulted in basic system reform and service enhancements at the State Hospital and at the community level for targeted adults and targeted children and adolescents in the State. With court approved closure of the legal issues visible on the horizon, the work of this group may be basically finished. This vehicle provided momentum for consensus building, provided initial direction for reform and a relatively safe environment for high emotion.

The Legislature

Without the support of the citizen legislature of Wyoming, none of this would be possible. Incrementally since 1996, this group has more than doubled the amount of State funds for community mental health centers. They have allowed flexibility in the use of State funds for both the Wyoming State Hospital and at the community level so the system could redirect resources to build state of the art

services and to make minor adjustments as the system dealt with inevitable learning curve lessons. In return, they have asked to be kept informed of the process and results. At this point in time, this group has shown interest in outcome measures, the capacity for which they have also been funding for the last two years.

Because outcome measures rely on a complex set of technical and cooperative efforts, some of which are in place and others which are being developed, providers and Division staff alike are working hard to keep this part of the bargain. Increasingly, the system demonstrates effectiveness with an increasingly sophisticated information system. We share the information we generate now and will continue to share more detailed information as the data system capacity grows.

We are confident in the outcomes that now show improvement for consumers and we are confident that our future outcomes will be equally positive because of the quality components with which we are building the system and which are at least partially described in this plan.

The Wyoming Alliance for the Mentally Ill (WYAMI)

The sustained efforts of a few people over the years have coalesced a statewide thinly spread set of family members into a viable education and advocacy oriented group. The Wyoming Alliance for the Mentally Ill, boasts a membership of over two hundred persons and they annually host a professional and family oriented, informative and well attended statewide meeting. The recipient of Mental Health Block Grant funds on an ongoing basis, they provide a statewide "800" number information and referral service. Most recently, with Block Grant funds provided Wyoming through a supplemental budget increase from the National Legislature, WYAMI is beginning a statewide "family to family" education program. They have scheduled the first training for family member trainers for this project later this month (November, 2000). Their tireless participation in the Partnership, Planning Council and countless other input meetings has informed the system when no other family or consumer voices were readily available or heard.

UPLIFT (Wyoming's Chapter of the Federation of Families)

People raising kids are busy, and generally strapped for cash, time and energy, especially if they are copying with a child with behavioral or emotional issues. We have learned from them, that copying with fragmented and multiple Systems of Care only places more of a drain on their precious time, energy and money.

During the last three years, this organization has become a player in the system due to their successes in garnering grant funds for projects that benefit children and their families, enhances the System of Care and places their representatives at important tables of conversation with policy makers, providers and Legislators alike.

The Wyoming Association of Mental Health and Substance Abuse Centers (WAMHSAC).

Before there was a public mental health "System" in Wyoming or a governmental "Division," there were mental health directors and their boards with a few mental health offices scattered around the State. They individually presented their center needs before the joint appropriations committee each biennium and ran their centers in response to local need. WAMHSAC's voice continues input to the system at planning, legislative, policy and program development levels.

The stage seems set for more stakeholder voices to be taken into account, not only to set direction and policy but to "make the case" as it were, to the Legislature and just as importantly, to the public at large. The case the public needs to hear with the most understanding is the value of acceptance and integration of all persons into normative society. The Mental Health Division, WAMHSAC and the Wyoming Legislature all put together, cannot make the case to the public as effectively as can one clear consumer or family member voice.

Protection and Advocacy (P and A, Inc.).

Integrally involved with the lawsuit and the resolution process, this group provides monitoring of parts of the system and input primarily to the Partnership. It's citizen representatives perform a gracious but effective approach to monitoring services, facilitating resolution of service glitches and participating in the various input venues mentioned earlier in this document.

The Wyoming State Hospital (WSH).

From institutional, largely custodial care to a redefined set of active treatments is where this entity has moved itself. As such, it is no longer just the recipient of those individuals which communities either could or would not treat or tolerate. While the system continues to accommodate new roles for this hospital, the core staff at the hospital pursues their vision of becoming an active player in the planning support of and in some cases, the provision of community type services. Because the Administrator of the hospital also administers the Mental Health Division, the role changes of the hospital have been blended with the service enhancements the system has made. Therefore it's voice is at all tables of discussion.

Statewide Ad Hoc Work Groups.

These have been numerous in number, diverse in their tasks and continually are created and terminated when their tasks are finished. All population groups and major service areas in the state have received focused attention through this process and is how many service models of best practices evolve in the System of Care.

The Mental Health Division.

The Division manages the provision of community based mental health services throughout the State by contracting with 16 certified Community Mental Health Centers who each provide required and additional services in response to local

community need. Biennial on site reviews are conducted according to Standards to assure a minimum level of quality exists at each center. Accountability is accomplished via monthly utilization reports, the electronic submission of data to the division MIS, and by special reports relating to Federal grants and focused or specialized services.

The Division has broadened the scope of it's activities, while still performing it's basic tasks of policy development, Standards monitoring, flowing and monitoring funds allocated to the system and producing information for system decisions. Successful acquisition of grant funds beyond the usual Block Grant dollars, sponsoring several statewide initiatives and regular contact with constituents other than public providers are some of the new activities undertaken during the last 4 years particularly. Planned additional staff can help assure that these new activities can continue.

Consumer Groups and Voices.

The Division has sponsored two statewide consumer conferences in the last two years and one Statewide Leadership Training event. Out of these activities is emerging a clearly identified group of consumers who express interest in developing their voices as a group on a statewide, regional and local basis. They have been introduced to Recovery principles and express a more than passing interest in implementing them statewide in the public Mental Health System of Care.

Additionally the Division hired, now 3 years ago going on 4, a state level consumer advisor. She has visited most regions of the State, meeting with many consumers and a few family members. The feedback from this process, nearly on a one to one basis and from the conferences has informed the Division as to their desires and needs. At the consumer's request at the first conference, the second was opened up to Clinicians and Administrators. The response was excellent and we had our first taste of consumers in a reciprocal dialogue with service providers, therapists, and support staff. Feedback from professionals and consumers alike was quite positive about this aspect of the conference.

Next the Division will activate regular Leadership Academy events around the State, with or without funds from a grant application submitted just this last September, 2000. Participating in community decision making bodies and events, including sitting on Board of Directors for mental centers, creating a voice advocating for their needs and desires as a group or in groups and rejoining or maintaining their positions in local communities are just some of the goals envisioned being achieved through planned consumer activities.

B. The Money

State Funds.

Throughout this document, flexible funding with accountability has been stressed, for it is viewed as the great enabler of enhanced services. The trusting partnerships that are functioning to achieve flexibility need to be carefully defined, refined and nurtured. A conversational and informational loop needs to be firmly and continuously in place among consumers, providers, the Executive Branch, the Division, the Legislature and other stakeholders. As this becomes "institutionalized" within the system, we must be careful to maintain the balance between trust and accountability information. Easily understandable outcomes and visible quality assurance measures are viewed as essential in maintaining the trusting partnerships that enable this very valuable flexibility feature of the system.

The data system under development, and increasingly able to produce useful information is considered a cornerstone in this trusting alliance. Quality Assurance programs are in place in all centers, but with large variances in kind and usefulness. The use of national standards needs to be more thoroughly explored, or a credible alternative put in it's place.

As has been pointed out earlier in this plan document, State General funds to the community based System of Care has increased by 125% since 1996, going from approximately 5M to more than 11M to 1999. Two more million is being requested this year that, if appropriated by the Legislature, will support the integration of services at community based levels. Additional funds are being requested for some increases in the cost of doing business at the Wyoming State Hospital, namely for higher utility bills and especially for increased costs of newer, more effective medications.

The opportunities to increase flexibility for the use of State funds for mental health services, both community based and State Hospital based, will continue to be explored.

<u>Medicaid, Medicaid Waivers and Kid's Care.</u>
Medicaid, functioning under the Rehabilitation Option in Wyoming is an important part of the funding mix for the Mental Health System of Care. It adds approximately 5M to community based services. However Medicaid retains several rigid features and a revision of funding categories and definitions of services have been drafted. While it remains to be seen what increase in flexibility is achieved through these draft revisions, it is anticipated that Medicaid will have a better "fit" with the use of State funds and may accommodate some limiting features of the Professional Licensing Board requirements for professional, and billing eligibility status, in Wyoming.

Waivers are being explored that may enable residential care for minors, age 21 and under. This application has been submitted to the Federal levels of Medicaid for review and the results of their review are not yet known. A Home and Community Based Waiver for a variety of other services is in exploratory discussion at Department and Policy levels of Wyoming State Government.

In 1998, Wyoming authorized and implemented the Federal Children's Insurance Program (CHIPS). While taking a while to implement, the enrollment has been highly successful to date, with more than double the number of children enrolled than were targeted for year one. This program was enhanced for it's second year to include more eligible children, by increasing the income limits of Wyoming families, to 150% of poverty levels. As successful as the individual

program has been, the increase of referrals to the mental health system of children enrolled in this program has been minimal.

Private Insurance Providers.
The pursuit of parity is the key here. Legislative initiatives to accomplish this have failed in recent Legislative sessions, but is being pushed again this year. This improvement is needed to assist persons of all ages utilize a proven set of economically viable and effective treatments. The Division will support efforts to the accomplishment of parity in Wyoming.

Federal Grants.
These grants, including the Block Grant, have been highly effective in Wyoming for introducing new and innovative services throughout the State. And the Division has successfully applied for additional funds to launch other statewide initiatives, including a Latino Consensus Project, and a Children's Early Screening Project. Federal Funds have supported in major ways, the enhancement of our data system as well.

With additional manpower at the Division level, it is anticipated that these and other Federal funds will find their way into Wyoming. Achieving Cultural Competency, further enhancement of Children's Services,

The Blending Process: Realities and Possibilities.
The Substance Abuse and Mental Health Administration has, in the last few months, determined that Block Grant funds from its' Substance Abuse Division and from its' Mental Health Division, may be used to fund services and projects for Persons with Co-Occurring Disorders. Funds from each Division however, must be spent on their respective service elements, and tracked separately. It is anticipated that for Federal and State funds alike, explorations of other blending opportunities will be painstakingly slow, due to targeted population, targeted outcome and accountability requirements of each funding source. Flexibility, within broad categories of populations to be served with specific outcome and financial tracking mechanism, appears to hold the most promise for the future time period being considered in this planning document.

AN INVITATION

TO HELP US

LOOK OUT

TEN YEARS

III. A Ten Year Vision - The Public Health View for Healthy Communities in Wyoming

It may seem a little smug to think out 10 years, when so many variables are either unknown or seem beyond control. But we have chosen to look at our current state of affairs, look at what trends suggest the future may be like, and prepare as best we can for that future. Without a dream, direction does not get defined and goals do not get set. We know that there is more reason now than ever before for persons with mental illness and emotional disturbance in Wyoming to have hope in their lives. In the pursuit of excellence in our service system and to instill hope for our primary consumers, the following goals seem worth pursuing in Wyoming.

1. To have Recovery Principles govern Rehabilitation and treatment activities for persons with serious mental illness in the State of Wyoming.

2. To have CASSP Principles govern treatment and support activities for children and adolescents with emotional disturbances and their families.

3. To create and adopt a formal Wyoming Integrated Mental Health Services Model inclusive of Community Based Mental Health Centers and the Wyoming State Hospital.

4. Assure accessibility to and appropriate services for every Wyoming citizen by implementing a full range of services in 4 to 5 defined regions throughout the state.

5. To lead a reform of Child and Adolescent Services in Wyoming.

6. To meet national criterion for Culturally Competent mental health services.

7. To establish a self run Consumer Leadership Academy and a Consumer Empowerment Council.

8. To define and implement a basic infrastructure cost of living enhancement plan to assure the ongoing viability of the system.

9. To either adopt a majority chosen National Mental Health set of Standards or revise Wyoming Standards to meet or exceed a majority chosen set of National Standards.

10. To fully operationalize a comprehensive integrated set of input, process and outcome measures and publish stakeholder oriented and research quality reports.

11. To lead the nation in utilizing flexible funding linked with accountability measures to assure the continued creativity of the Mental Health System of Care in the State of Wyoming.

12. To develop a comprehensive mental health technology plan that enables the mental health system to take advantage of technological developments during the next 10 years.

Epilogue:

This Plan reflects a distillation of information, sentiment, consensus building and some wishful thinking that has been expressed in multiple venues by multiple stakeholders around the State during the last 5 years. It was not designed to state the specific idea or dream of every stakeholder in the system. An attempt was made however, to suggest possibilities in broad enough categories that the major goals and objectives of a majority of people could be captured as an “action item”. If it is not apparent where your idea fits, it is only due to limitations of the human mind and language to make it obvious in written form.

This is intended to be a living document; additions, changes and priority setting can begin on the very day it is “unveiled.”

The Wyoming Public Mental Health System of Care Plan (update) March 2001

GOALS, OBJECTIVES AND ACTION STEPS
January, 2001 through June, 2002

The Wyoming Public Mental Health System of Care Plan (update)
March, 2001

GOALS, OBJECTIVES AND ACTION STEPS
January, 2001 Through June, 2002

On November 1, 2000 many stakeholders from around the State of Wyoming and from the National and Regional Offices of the Center for Mental Health Services, provided input and responses to the directions, values and goals contained in The Wyoming Public Mental Health System of Care Plan. Below are Action Steps that will bring alive those directions, values and goals. The first grouping of Action Steps are for the following 18 months, which will guide us through the second year of our current biennium ending June 30, 2002. Most of these Action Steps contain enough detail to know the what, who and when about the Goals listed. Names listed indicate persons who may participate in overseeing and moving projects forward. These lists of names are not exhaustive however and do not reflect all those ultimately who will be involved with any particular project.

A second group of Goals and Action Steps reflect plans for the next two bienniums, July 1, 2002 through June 30, 2004 and July 1, 2004 through June 30, 2006.

GOAL: TO PROMOTE CONSUMER CHOICE, EMPOWERMENT and LEADERSHIP.

Objective: ***To Comprehensively Implement Psychiatric Advance Directives (PAD) in Wyoming.***

Action Steps**:** 1) Complete PAD Handbook and Distribute Statewide.

Chuck Hayes, Rommel Reedy, and University of Illinois Workgroup, by February 28, 2001.

2) Establish Multi-Purpose PAD Website that includes a Central Registry and most items contained in the PAD Handbook.

Marla Smith, Rommel Reedy, Chuck Hayes, by July 31, 2001.

3) Pilot up to 6 PAD's, obtaining feedback from statewide reference group of consumers, mental health professionals and involved attorneys.

Chuck Hayes, Rommel Reedy, Doug Moench, by June 30, 2001.

4) Sharing statewide, any useful information obtained by Piolot PADs.

Chuck Hayes, by July 31, 2001.

5) Plan fuuture training and research activities with Dr. Cook and Genevieve Fitzgibbon with the University of Illinois at Chicago.

Chuck Hayes, Rommel Reedy, and Marla Smith, by January 11, 2001 and on an ongoing basis until the research project is complete in the State of Wyoming.

6) Evaluate the effectiveness of the current Statewide Outreach Programs being funded with Mental Health Block Grant funds and determine if a "model" should be funded in the future.

Assigned Division staff, Mental Health Planning Council Members, by September 30, 2001.

Objective: ***To Establish an Ongoing Consumer Leadership Academy.***

Action Steps: 1) If awarded, implement Consensus Building Grant Application.

Dolores Jimerson, Julia Peterson, Marilyn Patton, and Chuck Hayes, beginning March 15, 2001 and ongoing through October 31, 2003.

2) If not awarded, request Mental Health Block Grant funds for use in implementing a downsized Leadership Academy Project.

Chuck Hayes and Marilyn Patton by March 30, 2001.

3) In either case, conduct a minimum of 5 Leadership Academy Training events around the state.

Dolores Jimerson, Julia Peterson, and Chuck Hayes by September 30, 2002 .

Objective: ***To Establish and Continue Family to Family Training for Parents or Significant others of Adults with Serious Mental Illness.***

Action Steps: 1) Complete contract with WYAMI for training of trainer and Training of family members through September 30, 2001.

2) Request Mental Health Block Grant funds to continue indefinitely the Family to Family training events in Wyoming.

Marilyn Patton and Chuck Hayes for an indefinite and ongoing time period.

Objective: ***To determine the usefulness of, and implement as appropriate, a Consumer Run Self Recovery Program, called "Peer to Peer".***

Action Steps: 1) Obtain full description from NAMI.

2) Distribute to Consumers and Family Members for feedback purposes.

3) Host conference call to determine whether to pilot a "Peer to Peer" Program and if so where, and to generate support for funding, perhaps by Mental Health Block Grant funds.

Julia Peterson and Chuck Hayes, by June 30, 2002.

Objective: ***To continue independently administered Consumer Surveys.***

Action Steps: 1) To establish continued funding for periodic Consumer Satisfaction Surveys.

Marla Smith and Marilyn Patton, Ongoing.

Objective: ***To establish Consumer and Family Involvement in Monitoring Activities Of the system.***

Action Steps: 1) Inclusively plan how this will occur.

Pablo Hernandez M.D., Mental Health Planning Council Appointee, et. al., by December 31, 2003.

Objective: ***To establish Recovery and CASSP Principles as guidelines and values for Services provided to Adults and Children with Serious Mental Illness.***

Action Steps 1) To place Recovery Principles in the agenda of the 3rd Annual Consumer Conference and in the agenda of Leadership Academy Training events.

Chuck Hayes and Julia Peterson, June 30, 2001.

2) To suggest statewide Recovery training, targeted to clinicians, to training committee of the Division that involves an ad hoc input group from WAMHSAC; and obtain Mental Health Block Grant funds for such purposes.

Chuck Hayes, June 30, 2001.

3) To implement statewide training targeted to clinicians.

Chuck Hayes, Carol Day, Marilyn Patton, Dolores Jimerson, Marla Smith, and Lisa Brockman, beginning November 1, 2001.

4) To host ad hoc group of inclusive members to guide the activities of general implementation of CASSP principles**.**

5) To host statewide workshops for clinicians and administrators on CASSP implementation tasks**.**

Objective: ***To continue work of Consumer Advisor to the Division.***

Action Steps: 1) Host at least 5 regional meetings with consumers focusing on:

- Housing
- Employment and Education
- Psychiatric Advance Directives
- Recovery Principles
- Primary Health Care Assessment

2) Coordinate Activities related to Annual Consumer Conference.

3) Consult with Homelessness Programs.

All promoted and monitored by Julia Peterson, State Consumer Advisor and Chuck Hayes.

GOAL: TO PROMOTE HEALTHY COMMUNITIES

Objective: ***To achieve Public Health Modeled, Integrated Community Based Services by CMHCs.***

Action Steps: 1) Incorporate Integrated Service language into contracts with providers, to include Primary Health Care for Wyoming, using consensus building methods.

Pablo Hernandez,M.D., Carol Day, Chuck Hayes, and WAMHSAC Appointees, by January 30, 2001.

2) Negotiate methodology and time lines with WAMHSAC and WSH, for implementing appropriate integrated services.

Carol Day, Pablo Hernandez, M.D., and Chuck Hayes, by February 28, 2001.

3) Identify training and/or multi-agency collaborative efforts that will promote integrated services, especially for Primary Health Care for persons served by CMHCs and Wyoming State Hospital.

WAMHSAC Training Committee, Mental Health Planning Council, Carol Day, Pablo Hernandez, M.D., Suzy Wigetman, Chuck Hayes, by March 30, 2001.

4) Schedule, coordinate and execute identified supportive training and multi-agency activities.

Carol Day and Suzy Wigetman.

5) Plan and implement a statewide Mental Health Education Program for General Practice Physicians, led by Dr. Zolchek and Dr. Weathers of WSH, planning to begin by February 1, 2001 and implementation to begin by April 1, 2001.

Objective: ***To Fund and Implement the Prevention Plan, as attached to the Wyoming Public Mental Health System of Care Plan.***

Action Steps:1) Obtain funding from the legislature and MHBG as needed to finance the activities of this objective**.**

2) Plan and Execute statewide training in Building Resilience.

Carol Day, et. al., by December 31, 2001.

3) Plan and Execute statewide training in Reducing Risk Factors.

Carol Day, et. al., by December 31, 2002.

4) Plan and Execute statewide training in Protective Factors.

Carol Day, et. al., by December 31, 2003.

Objective: ***To Implement Statewide Stigma Reduction Activities***

Action Steps: 1) Develop plan that uses integrated community efforts, to increase community awareness about the roots of mental illness and it's treat ability.

2) Develop plan that highlights the strengths of persons with mental illness who manage their lives within local communities.

3) Implement continuous action steps that are ongoing and supported by the Mental Health Planning Council.

Appointees from the Mental Health Division, WYAMI, UPLIFT, WAMHSAC and Mental Health Planning Council, by December 31, 2001.

GOAL: TO PROMOTE CULTURALLY COMPETENT MENTAL HEALTH SERVICES throughout Wyoming that utilize GUIDING PRINCIPLES and SYSTEM STANDARDS FOR CULTURAL COMPETENCY.

Objective: ***To provide ongoing statewide training to achieve three levels of cultural competency within the Public Mental Health System of Care.***

Action Steps: 1) Hire Mental Health Division Staff designated to have leadership responsibility for this goal.

Pablo Hernandez, M.D., Marilyn Patton by March 31, 2001.

2) Write and execute multi year training and event plan.

Person hired, begin by July 1, 2001.

GOAL: TO ENHANCE THE DATA MANAGEMENT INFORMATION SYSTEM

Objective: ***To complete transition to an all electronic transmission methodology for data input from providers***.

Action Steps: 1) Complete pilot of software programs.

Marla Smith, WAMHSAC Data Committee, June 30, 2001.

2) Begin electronic transmission of data from Centers and begin testing reliability of data.

Marla Smith, WAMHSAC Committee, beginning July 1, 2001.

Objective: ***To test functional assessments that are built into the data system.***

Action Steps: 1) Accumulate data, run reports, evaluate conjointly with WAMHSAC Data Committee.

Marla Smith, WAMHSAC Data Committee, beginning October 1, 2001.

Objective: ***To design reports useful for Division and provider level decision making, and for Division level research and policy development.***

Action Steps: 1) Determine all data streams available to the Mental Health Division and generate a variety of reports that seem of reasonable use to the system.

2) Disseminate draft reports for constructive input by stakeholders.

3) Determine ongoing reports to be generated for a 12 month period for further practical evaluation and adoption by the system as a whole.

Marla Smith, Division Data Analyst, Division Staff, WAMHSAC Data Committee, other stakeholders, beginning July 1, 2001.

Objective: ***To protect the confidentiality of data that may contain individual identifiers.***

Action Steps: 1) To implement and manage privacy protection procedures as necessary which insulates necessary which insulates certain data containing individual identifiers.

Marla Smith, Pablo Hernandez, M.D. and WAMHSAC Data Committee by October 31, 2002.

Objective: ***To begin utilizing Outcome Measures for Contracting and Decision Making Purposes.***

Action Steps: 1) Place language in contracts which requires performance indicators.

Carol Day, Chuck Hayes, Pablo Hernandez, M.D., beginning July 1, 2001.

2) Generate a variety of consensus agreed to reports throughout the biennium for use by system stakeholders.

Marla Smith, WAMHSAC Data Committee, Mental Health Planning Council and others, throughout FY 03 and FY 04.

GOAL: TO PURSUE FLEXIBLE FUNDING FOR PROVIDERS.

Objective: ***To redefine Persons Served by the Wyoming Public Mental Health System of Care.***

Action Steps: 1) Draft new definitions for Adults and Children and

Adolescents and their Families to served by the system.

Carol Day and Chuck Hayes, by February 15, 2001.

2) Gain consensus from all stakeholders and Mental Health Division.

Carol Day and Chuck Hayes, by February 30,2001.

Objective: ***To develop State funded contracts to serve persons in need with appropriate treatments, as designed by local CMHCs.***

Action Steps:1) Rewrite current contract language to enable the above objective.

Carol Day and Chuck Hayes, by January 15, 2001.

2) Develop consensus for revised contract language.

Carol Day and Chuck Hayes, by February 15, 2001.

3) Finalize contract language.

Carol Day and Chuck Hayes, by March 15, 2001.

4) Execute revised contract.

Mental Health Division Staff, CMHCs, by June 30, 2001.

Objective: ***To promote Parity by Private Insurers for Mental Health Services.***

Action Steps: 1) Provide information to Legislators.

Pablo Hernandez, M.D., WAMHSAC designees, as long as necessary.

2) Collaborate with advocacy groups, such as WYAMI, UPLIFT, the Mental Health Planning Council, and others to provide a coordinated statewide and focused information about the needs for and benefits of parity in insurance coverage.

Objective: ***To rewrite the Medicaid Manual, evaluate Waivers and integrate "Kid's Care" into funding streams.***

Action Steps: 1) Complete Medicaid Manual rewrite.

WAMHSAC, Mental Health Division Staff and Medicaid Personnel, by February 20, 2001.

2) Write and Promulgate related Rules and Regulations.

Office of Medicaid, anticipated by June 30, 2002.

3) Evaluate Waivers for Respite and Long term care and pursue appropriate ones.

Lisa Brockman, Marilyn Patton, Pablo Hernandez, M.D., WAMHSAC, and the Behavioral Health Care Committee for Children by December 31, 2001.

GOAL: TO EMPHASIZE STATE AND LOCAL LEVEL COORDINATION OF SERVICES TO CHILDREN, ADOLESCENTS AND THEIR FAMILIES.

Objective: ***To initiate State level discussions and planning at Governor's Cabinet level and at Department Levels promoting coordinated approaches to serving Children, Adolescents and their Families.***

Action Steps: 1) Discuss with Wyoming Department of Health Director.

Pablo Hernandez, M.D., Spring of 2001.

2) Guided by the above, promoting discussions at other levels of State Government and considering the value of a "guidance" cabinet level or ad hoc level group.

Pablo Hernandez, M.D., Marilyn Patton, and Lisa Brockman, Spring of 2001.

3) UPLIFT and WAMHSAC discussions and planning.

Carol Day and Chuck Hayes, beginning August, 2001.

4) Executing appropriate training and other events, guided by all the above.

Lisa Brockman and Carol Day, beginning November of 2001.

5) Complete System of Care document for Services to Children, Adolescents and their Families.

Behavioral Health Care Committee for Children, December 31, 2001.

GOAL: TO PROMOTE SYSTEM WIDE WORKFORCE DEVELOPMENT

(Note: The funds obtained since 1993 have all gone to support an increase in, or improvement of services in the system. Cost of living increases, higher salaries paid by neighboring states

since 1995 and other cost pressures have not resulted in increased unit cost reimbursement rates that enable competitive recruitment and retention activities.)

Objective: ***To develop information and a plan for RECRUITMENT AND RETENTION of treatment, case management and other appropriate staff, throughout the Mental Health System of Care in Wyoming.***

Action Steps:

1) Accumulate staffing pattern, costs associated with successful recruitment and retention of staff, and other relevant information, on a statewide basis.

   WAMHSAC Designees and Mental Health Division Staff, by June 30, 2001.

2) Determine essential and desirable staffing ratios within the system.

   WAMHSAC Designees and Mental Health Division Staff, by June 30, 2001.

3) Develop statewide Recruitment and Retention Plan.

   Chuck Hayes, Carol Day, Wyoming State Hospital, and WAMHSAC Designees, by August 31, 2001.

4) Pursue Recruitment and Retention Efforts for all mental health providers.

   Mental Health Division, Wyoming State Hospital, and Stakeholder Designees, through 2008.

GOAL: TO ACHIEVE NATIONAL ACCREDITATION FOR ALL INPATIENT AND COMMUNITY BASED SERVICES PURCHASED BY THE STATE.

Objective: ***To provide statewide training about accreditation and provide technical assistance during Biennial On-Site Reviews.***

Action Steps:

1) Provide statewide training in accreditation procedures, obtain funding as appropriate and schedule and execute said training.

   Mental Health Division Training Committee, by March 2002.

2) Plan for Technical Assistance to be provided regarding accreditation during Biennial On-Site Reviews, beginning in the Spring of 2001.

   Marilyn Patton, Chuck Hayes, Suzy Wigetman and Carol Day.

3) Fund certain CMHC expenses in achieving National Accreditation for all contracted providers.

Pablo Hernandez, M.D., by July 1, 2003 through June 30, 2008.

4) Maintain Wyoming State Hospital CARF Accreditation.

Ongoing.

GOAL: TO ASSURE QUALITY CARE AND SERVICES AS APPROPRIATE, THROUGHOUT THE SYSTEM.

Objective: ***To review all services listed below and determine if and what enhancements are needed for each, determine associated costs and when enhancements might be reasonably accomplished.***

- Community based crisis intervention, including regional inpatient care
- Supported education
- Forensic Evaluations
- Transitional Services for Older Adolescents
- Early Identification and Intervention Programs
- Specialized Services
  - Elderly
  - Co-occurring
  - Deaf
- Residential Services, including a Statewide Plan for acquisition of Vouchers and location of various residential units.
  - WSH
  - Regional Care
  - Community Based Crisis Beds
- TFC
- Prevention
- Outpatient Clinical Services
- Recovery and Rehabilitation Services
- Education
- Case Management
- Quality of Life
- Regional Crisis Response Capacity that includes respite care, rapid assessment, a range of residential treatment, including inpatient
- Plans to meet the needs of persons with Acquired Brain Injuries

Objective: ***Develop plan for the enhancement of services determined appropriate.***

Action Steps: 1) Appoint Strategic Planning Group for FY 04 to carry out plan development.

Pablo Hernandez, M.D. by November, 2001.

2) Coordinate with Statewide Needs Assessment Report, if funded by the Mental Health Planning Council.

Objective: ***Update Public Mental Health System of Care Plan accordingly.***

Action Step: Update plan, by December 31, 2002 and annually thereafter.
Appointed Division Staff.

The Wyoming Public Mental Health System of Care Plan (update) March 2001

GOALS, OBJECTIVES AND ACTION STEPS
January 1, 2002 Through June 30, 2006

The Wyoming Public Mental Health
System of Care Plan (update)
March, 2001

LONG TERM GOALS AND OBJECTIVES
July 1, 2002 Through June 30, 2006

This section reflects long term or continuous goals and objectives and contains more limited detail as to specific objectives, action steps and time lines. It is expected that considerably more detail will be added annually, via updates to this plan.

GOAL: TO OBTAIN CONTINUOUS, BROAD BASED STAKEHOLDER INPUT.

Objectives:

1) Maintain, train and support the Mental Health Planning Council to achieve it's enhanced goal of observing through data and other information review and providing input to the Mental Health Division, about the System of Care.

- Membership already exceeds federal requirements to represent consumers, stakeholders and other interested parties.
- Assigned Division Staff.
- Current and Indefinite Time Frame.

2) Maintain and support the Adult Services Committee of the Division.

- Develop best practices and service development recommendations as needed.
- Membership includes private and public providers, consumers and stakeholders.
- Assigned Mental Health Division Staff.
- Current and Indefinite Time Frame.

3) Maintain and support the Child and Adolescent Behavioral Health Committee of the Division.

- Develop best practices and service development recommendations as needed.
- Membership includes private and public providers, consumers and stakeholders.
- Assigned Mental Health Division Staff.
- Current and Indefinite Time Frame.

4) Create Ad Hoc Task Force work groups as needed to supplement the Adult and Child and Adolescent Committees. Current groups include Task Forces' on:

- ♦ Services for the Elderly.
- ♦ Services for Persons with Co-Occurring Disorders (Mentally Illness and Substance Abuse).
- ♦ Services for Persons who are Deaf or Hard of Hearing.
- ♦ Assigned Division Staff.
- ♦ Indefinte Time Frame.

5) To continue Statewide Town or other Meetings at least once a biennium for citizen input to the system.

Marilyn Patton and other Mental Health Division staff beginning again July, 2003.

GOAL: CONTINUOUSLY PROMOTE CONSUMER CHOICE, EMPOWERMENT and LEADERSHIP ACTIVITIES WITHIN THE SYSTEM OF CARE.

Objectives: 1) Provide statewide training and marketing events for Psychiatric Advance Directives.

- ♦ Assigned Mental Health Division and Wyoming State Hospital Staff.
- ♦ Training conducted biennially.

2) Evaluate Outreach Programs using quarterly reports submitted by participating providers.

- ♦ Mental Health Division staff, Mental Health Planning Council Members and WAMHSAC. (Mental Health Planning Council member representatives must include at least one consumer and one family member) by July 30, 2001.

3) If appropriate, write OUTREACH PROGRAM MODEL using input from FY 2001 experience.

- ♦ Assigned Mental Health Division staff and Mental Health Planning Council members, by March 30, 2002.

4) If appropriate, brain state funding for continuation of Outreach Program.

- ♦ Pablo Hernandez, M.D., by June 30, 2002.

- ♦ Continue Program indefinitely.

6) Develop an implementation plan for Emergency Detention Treatment Interventions .

- ♦ Define the operational and infrastructure elements.
- ♦ Pilot the envisioned Triage System.
- ♦ Wyoming State Hospital, Mental Health Division and WAMHSAC appointed persons, beginning April 1, 2003 (may begin as soon as July 1, 2001 if E.D. bill is passed by the 2002 Legislature)
- ♦ Pablo Hernandez, M.D., and appointees, beginning March 1, 2002.

GOAL: IMPLEMENT PERIODIC, INDEPENDENTLY CONDUCTED REVIEWS OF THE SYSTEM OF CARE.

Objectives: 1) Using Mental Health Block Grant funds, conduct periodic Needs Assessments of the System of Care, utilizing independently contracted professionals who are knowledgeable and experienced in the mental health field and in system-wide needs assessment protocols.

- ♦ Arranged by assigned Mental Health Staff and Mental Health Planning Council Members.
- ♦ First assessment to be completed by December 30, 2002.
- ♦ Assessment of the Role of the Wyoming State Hospital to be included.

It is anticipated that assessments would be conducted at least every 4 years thereafter. May be done more frequently depending upon changes occurring in the system.

2) Fund certain expenses for Community Mental Health Centers achieving National Accreditation.

Pablo Hernandez, M.D., beginning July 1, 2002.

3) Provide Technical Assistance for meeting National Standards requirements during Biennial On-site Reviews and at other times as pre-arranged with interested Community Mental Health Centers.

Assigned Mental Health Division and Wyoming State Hospital Staff, beginning March 1, 2001 and continuing through June 30, 2006.

4) Maintain CARF Accreditation at Wyoming State Hospital.

- Current and Continuous

5) Continue Wyoming State Hospital Consumer Surveys.

6) Continue Independently Conducted Community Based Consumer Surveys.

GOAL: TO ESTABLISH AN ONGOING CLIENT RIGHTS AND REVIEW PROGRAM

Objectives: 1) Establish an Ombudsman Program

- Determine needed Infrastructure to support the Ombudsman Program.
- Determine a basic operational protocol for the Ombudsman Program.
- Obtain funding, beginning July 1, 2003.

2) Develop a plan for consumers to participate in on-site reviews.

Craig Kirkland, Rommel Reedy, Suzy Wigetman and other Mental Health Division staff as assigned. WYAMI, UPLIFT, Consumer Representatives and others representing the interest of persons served will be significant players in the development of this program. Staff listed are those with client rights experience and who can assist with background supports for this piece of planning. Planning to begin by November 30, 2002, funding by July 1, 2003 and implementation by October 30, 2003.

GOAL: TO MAINTAIN AND IMPLEMENT "STATE OF THE ART" SERVICES AND PROGRAMS WITHIN THE WYOMING PUBLIC MENTAL HEALTH SYSTEM OF CARE.

Objectives**:** 1) To contract for only Best Practice Services as provided by qualified staff.

- A current and ongoing objective.
- Update and Add Best Practice Guidelines for All Services.

2) To develop, fund and implement a statewide recruitment and retention plan.

- Plan written by March 31, 2001.
- Funding request placed in budget by June 30, 2001 for use beginning July 1, 2002.
- Recruitment and Retention activities will be continuous.

3) To provide annual training for clinical and program support staff.

- Annual constitute a statewide training committee.
- Determine by August 30, annually the training needs for the following 12 months.
- Allocate Mental Health Block Grant funds accordingly.
- Contract for and monitor planned training events.
- Arrange for CEUs to always be attached to any training offered.
- Arrange for funds for training, as appropriate.

4) To develop fund and implement a statewide recruitment and retention plan.

GOAL: TO ACTIVELY PURSUE COORDINATED AND INTEGRATED SERVICES FOR CHILDREN, ADOLESCENTS AND THEIR FAMILIES.

GOAL: TO CREATE A COMPREHENSIVE AND INTEGRATED INFORMATION SYSTEM THAT INCLUDES MULTIPLE INFORMATION STREAMS.

GOAL: UPDATE PLAN ANNUALLY.

GOAL: CONTINUE TO ENHANCE SERVICES THROUGHOUT THE SYSTEM.

- Housing
- Convalescent Leave
- Educational/Vocational Programs
- Local/Regional Inpatient Care
- Assessment of Risk; Transitional Care for persons ready for a more appropriate placement.
- Family to Family
- “Peer to Peer” Programs

- Monitoring Teams
- Forensic
  - Training
  - Evaluations
- Basin SIP development
- Enhanced Aging SIP (s)